For office use only:
Submitter ID no._____
Date:_____
Mode:_____

NCI / COG Phase I Consortium
Pediatric Oncology Preclinical Protein-Tissue Array Project (POPP-TAP)
Cell Line/Xenograft Information Submission Form

---

1. Type of submission:

□ Cell line □ Xenograft

Name of Cell line/Xenograft: _____

ATCC number *(if available)***:**_____

---

2. Provider of cell line/xenograft contact information:

Name _____ Institution _____

Mailing Address _____
City _____ State _____ Zip _____

Telephone ( ) - ( ) - _____ Fax ( ) - ( ) - _____
(if international, please include the country code for the telephone and fax)

E-mail address(es) _____

---

3. Demographics of patient from whom cell line/xenograft was derived:

A. Patient's Age at Diagnosis**:** _____ *(years)*

B. Gender**:**

□ Female □ Male

C. Race *(check all that apply)***:**

□ African American or Black
□ American Indian or Alaska Native
□ Asian
□ Native Hawaiian or other Pacific Islander
□ White
□ Unknown
□ Other *(specify)***:** _____

D. Ethnicity *(check only one)***:**

□ Hispanic or Latino(a)
□ Non-Hispanic or Latino(a)
□ Unknown
□ Other *(specify)*: _____

For office use only:
Submitter ID no._____
Date:_____
Mode:_____

E. Is the tumor from someone with a known genetic syndrome?
- □ No
- □ Yes (i*f yes, please indicate which genetic syndrome)*: _____

---

4. Characteristics of tumor from which cell line/xenograft was derived

A. Diagnosis:
- □ Acute Lymphoblastic Leukemia (ALL)
- □ Acute Myeloid Leukemia (AML)
- □ Ependymoma
- □ Hepatoblastoma
- □ Ewing's Family of Tumors (PNET)
- □ Medulloblastoma
- □ Neuroblastoma
- □ Glioma NOS
- □ Non-Hodgkin's Lymphoma (NHL)
- □ Osteosarcoma
- □ Rhabdoid tumor *(please indicate region)*:_____
- □ Rhabdomyosarcoma (Embryonal)
- □ Rhabdomyosarcoma (Alveolar)
- □ Wilm's tumor
- □ Other (*please indicate)*: _____

B. Tumor Stage at initial diagnosis:
- □ Localized
- □ Regional
- □ Metastatic

C. Tumor Status *(at the time of cell line/xenograft establishment)*:
- □ Newly diagnosed
- □ Recurrent

D. Prior Treatment *(check all that apply)*:
- □ No prior treatment
- □ Prior chemotherapy
- □ Prior XRT

E. Tumor cells obtained from:
- □ Primary site
- □ Metastatic site

F. Description of anatomic site of primary tumor *(be as specific as possible)*:
_____

G. Description of anatomic site from which tumor cells obtained *(be as specific as possible)*:
_____

H. If you did not isolate this cell line/xenograft, indicate from whom you received it *(the arrows will indicate the succession of individuals and/or institutions who maintained this specific strain)*.

POPP-TAP ✍ Provider ✍ _____ ✍ _____

For office use only:
Submitter ID no._____
Date:_____
Mode:_____

I. Was an IRB consent form obtained for establishing the cell line or xenograft?

□ Yes
□ No
□ Not applicable
□ Unknown

Please provide any additional information regarding the IRB for this study:

_____
_____

---

5. Cell line characteristics (if submitting xenograft, proceed to next page)

A. Passage number on receipt *(if obtained from another laboratory)***:** _____

B. Method of establishment**:**

□ Culture
□ Passage through xenograft
□ Viral transformation

C. Culture media, sera, and other culture supplements**:**

_____
_____

D. Doubling time**:** _____ (*hours)*

E. Split frequency**:** _____ (*days)*

F. Current number of passages**:** _____

G. Has crisis occurred?

□ No
□ Yes (*please indicate which passage number*)**:** _____
□ Unknown

H. Do cells grow in soft agar?

□ No
□ Yes
□ Unknown

I. Do cells form tumors in mice?

□ No
□ Unknown
□ Yes (*if yes, please indicate which strain*)**:** _____

J. Date of most recent mycoplasma test *(MM/DD/YY)***:** ___/___/___

For office use only:
Submitter ID no._____
Date:_____
Mode:_____

K. Cell Line cryopreservation conditions:
% DMSO: _____
% Serum: _____
Other additives *(please indicate with %)***:**
_____
_____

---

6. Xenograft characteristics

A. Method of establishment**:**
□ Cell culture in vitro prior to xenograft establishment?
(*if selected, complete "Cell line characteristics" above as well)*
□ Direct transplantation

B. Number of cells injected to produce tumor, if relevant**:** _____

C. Orthotopic transplant?
□ No □ Yes *(if yes, specify location)***:**
_____

D. Mouse strain maintained in**:** _____

E. Doubling time**:** _____ (*days)*

F. Current method of maintenance**:**
_____
_____

G. Current number of passages**:** _____

H. Metastatic potential**:**
□ No
□ Yes *(if yes, describe metastatic sites)***:**
_____
_____

I. Earliest passage cryopreserved**:** _____

K. Xenograft cryopreservation conditions:
% DMSO: _____
% Serum: _____
Other additives *(please indicate with %)***:**
_____
_____

For office use only:
Submitter ID no._____
Date:_____
Mode:_____

7. Cytogenetic Characteristics

A. Has conventional cytogenetics been done?
- □ No
- □ Yes *(if yes, please summarize results or if possible submit the karyotype report)***:**

_____
_____

B. Has a spectral karyotype been done?
- □ No
- □ Yes *(if yes, please summarize results or if possible submit the spectral karyotype report)***:**

_____
_____

C. Are you submitting a conventional and/or spectral karyotype separately?
- □ No
- □ Yes ***(if yes, the karyotype may be submitted separately as an e-mail attachment or by postal or courier service – see addresses below. Be sure to include your full name, the cell line or xenograft name, the type of karyotype being submitted, and a description of any software needed to view an electronic file)***

D. Has conventional (i.e. metaphase) comparative genomic hybridization been done?
- □ No
- □ Yes *(if yes, please summarize results)***:**

_____
_____
_____

8. Molecular Biological Characteristics

A. Has any molecular screening of the cell line/xenograft been done?
- □ No
- □ Yes *(if yes, please complete the following molecular information)*

B. Were inactivating mutations or deletions of tumor suppressor genes identified (e.g., p53, PTEN, p14 (ARF), p16 (INK4A), p19, Rb, etc.)? *If yes, specify gene and mechanism of inactivation***:**

_____
_____

For office use only:
Submitter ID no._____
Date:_____
Mode:_____

C. Were activating mutations of oncogenes identified (e.g., ras)? *If yes, specify gene and the activating mutation if known***:**

_____
_____

D. Have amplified genes or chromosome loss/gain regions been identified?

□ Not evaluated □ No
□ Yes *(if yes, please list chromosomal regions and genes that are amplified)***:**

_____
_____

For the specific types of cancers listed below, please complete the following if applicable for each cell line/xenograft:

E. Acute lymphoblastic leukemia (ALL), Immunophenotype**:**

□ Mature B-cell □ B-precursor □ T-cell ALL

F. Acute lymphoblastic leukemia (ALL), Surface antigens (check all that apply)**:**

□ CD2 □ CD19 □ Other *(please specify)***:** _____
□ CD7 □ CD20
□ CD3 □ CD22 _____
□ CD10 □ CD34

G. Acute lymphoblastic leukemia (ALL), recurring molecular abnormalities**:**

□ MLL gene rearrangement □ Myc gene rearrangement
□ TEL-AML1 (ETV6-CBFA2) □ Other *(please specify)***:**
□ Bcr-Abl _____
□ E2A-PBX1

H. Acute myeloid leukemia (AML) FAB subtype**:**

□ M0 □ M3 □ M6
□ M1 □ M4 □ M7
□ M2 □ M5 □ Not known

I. Acute myeloid leukemia (AML), recurring molecular abnormalities**:**

□ MLL gene rearrangement □ Flt3 internal tandem duplication
□ ETO-AML1 □ -7/del(7)
□ PML-RARA □ Other *(please specify)***:**
□ MYH11-CBFB _____

J. Ewing Family of tumor cell lines/xenografts**:**

□ EWS-FLI1 Type 1 □ Aberrant translocation *(please specify if known)***:**
□ EWS-FLI1 Type 2 _____

For office use only:
Submitter ID no._____
Date:_____
Mode:_____

K. Glioma**:**

EGFR amplification	□ Not tested	□ Present	□ Absent

L. Hepatoblastoma**:**

? -catenin mutation	□ Not tested	□ Present	□ Absent

M. Medulloblastoma**:**

PTCH mutation	□ Not tested	□ Present	□ Absent
17p LOH	□ Not tested	□ Present	□ Absent

N. Neuroblastoma cell lines/xenografts**:**

MYCN amplification	□ Not tested	□ Present	□ Absent
1p LOH	□ Not tested	□ Present	□ Absent
11q LOH	□ Not tested	□ Present	□ Absent
14q LOH	□ Not tested	□ Present	□ Absent
17q gain	□ Not tested	□ Present	□ Absent

O. Osteosarcoma**:**

Rb LOH or mutation	□ Not tested	□ Present	□ Absent

P. Rhabdomyosarcoma cell lines/xenografts**:**

PAX3-FKHR	□ Not tested	□ Present	□ Absent
PAX7-FKHR	□ Not tested	□ Present	□ Absent

Q. Wilm's Tumor**:**

11p13 LOH	□ Not tested	□ Present	□ Absent
11p15 LOH	□ Not tested	□ Present	□ Absent
WT1 mutation	□ Not tested	□ Present	□ Absent
p53 mutational analysis	□ Not tested	□ Present	□ Absent

R. Other significant molecular characteristics not described in the above sections *(please describe below)***:**

_____
_____
_____
_____
_____
_____

9. Publications

A. Are there publications describing the cell line?

□ No

□ Yes (*if yes, please attach a copy, or provide references)***:**

For office use only:
Submitter ID no._____
Date:_____
Mode:_____

B. Are there publications describing the use of the cell line in drug testing?
- □ No
- □ Yes *(if yes, please attach a copy or, provide references)***:**

10. Drug Testing

Has the cell line/xenograft been used for drug testing?

□ No □ Yes □ Unknown

11. Intellectual property

Please check all that apply to the cell line or xenograft**:**

- □ Material is proprietary to the provider
- □ Material is proprietary to more than one individual or institution
- □ Material has one or more pending or issued patents
- □ Federal funding was involved in its development

12. Any Additional Information on the Cell Line or Xenograft

Information should be submitted by January 15, 2003, in order to facilitate the review process.

Submission forms may returned by post to:

Robert Gore-Langton, Ph.D.
EMMES Corporation,
401 N. Washington Street, Suite 700,
Rockville, MD 20850
U.S.A.

or by **FAX to 301-251-1355**. If needed, the country code prefix is 1.

For office use only:
Submitter ID no._____
Date:_____
Mode:_____

Additional information (e.g., karyotypes, references) may be sent as e-mail file attachments to pedarray@emmes.com. *This account is not monitored for inquiries.* Be sure to include your full name, the cell line or xenograft name, a description of the attachment(s), and a description of any software needed to view electronic files.

Submission inquiries may be made to Robert Gore-Langton rlangton@emmes.com . Include PEDARRAY in the subject line.

Other inquiries regarding this project should be directed to Dr. Malcolm Smith SmithM@ctep.nci.nih.gov.
